

Running head: ALCOHOL AND PEACEKEEPING

Alcohol Use and Stress During Peacekeeping Deployments¹

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¹The views of the authors do not necessarily reflect those of the Department of the Army, or the Department of Defense (para 4-3, AR 360-5).

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Abstract

The present study investigated the relationship between alcohol use and deployment stress during two peacekeeping deployments. Both operations involved U.S. Army soldiers deployed from Germany to areas in the former Yugoslavia. One set of soldiers (N=128) comprised a medical unit deployed to Croatia, whereas the other group (N=171) was a border patrol unit deployed to Macedonia. Both samples of soldiers deployed for six months and were surveyed regarding their alcohol use and reaction to various stressors. Results indicate that 14.2% of the medical unit and 14.6% of the border patrol unit reported trying to reduce tension by drinking more alcohol than usual. Those soldiers reporting an increase in alcohol use also report experiencing significantly greater stress from boredom, isolation, separation from spouse, and unit leadership than those who reported no alcohol increase. Limitations of the study and implications of the findings are discussed.

Alcohol Use and Stress During Peacekeeping Deployments

Alcohol use has often been viewed both culturally and in the professional literature as a common response to stress (Peyser, 1982). Although many types of stressors have been associated with drinking, occupational stressors have been specifically associated with "escape drinking" (cited in Holt, 1982). In the military, a unique set of job stressors are particularly likely to occur during peacekeeping deployments. Given the estimates of alcohol misuse in the military and the accompanying cost (Harig, 1991), the question of alcohol use and deployment stress has both practical and clinical relevance.

During a peacekeeping deployment, numerous occupational stressors arise. These stressors can be characterized by five related dimensions: isolation, ambiguity, powerlessness, boredom and threat (Bartone & Adler, 1994; Bartone, Vaitkus, & Adler, 1994). Some of these job stressors may also occur during conventional deployments but their unique combination provides a model for understanding the psychology of peacekeeping. The first dimension, isolation, refers to physically remote locations, culturally different surroundings, and difficulty communicating with home. Ambiguity refers to the unclear bureaucratic and hierarchical structure of UN deployments, the confusion surrounding mission definition and goals, and the fact that the deploying soldier's identity must shift from war fighter to peacekeeper. Powerlessness refers to the rules-of-engagement restrictions, limited activity and cultural barriers. Boredom refers to the tedium of repetitive, predictable peacekeeping duties that can compound the sense of the activity as meaningless. Finally, threat refers to fears of harm from physical danger as well as psychological threat from exposure to suffering.

These five factors as well as ongoing concerns about family and work environment comprise the major stressors facing peacekeepers. Such occupational stressors may lead to "escape drinking," or increased alcohol use. The current study surveys two units deployed on a peacekeeping mission to assess the relationship between alcohol use and deployment stressors, and to identify characteristics of those individuals reporting increased alcohol use.

Method

Participants. In May of 1993, a U.S. Army Task Force was deployed from Germany to Croatia for six months to provide medical support to the U.N. Protection Forces (UNPROFOR) in the former Yugoslavia (N=128, 60% response rate). In July of 1993, an Army infantry unit based in Germany deployed to Macedonia for six months to perform a conventional border patrol, or "observe and report" peacekeeping mission (N=171, 65% response rate). Both the medical and infantry units were used in the present study.

Procedure. The medical unit was given surveys before, during and at the end of their deployment. Extensive on-site interviews and observations were conducted throughout the deployment. The data presented here are taken from the mid-deployment survey¹, although information gathered from other sources is used to place the results in a meaningful context. The border patrol was surveyed immediately upon redeployment.

Instruments. Despite some variations, both the mid-deployment medical unit survey and the post-deployment border patrol unit survey used similar or identical items and covered the same general areas. (1) Sources of stress were assessed by a list of possible concerns about the deployment, unit functioning, and family issues. Respondents were asked to rate on a scale of 1 (none) to 6 (very high) the amount of trouble or concern they were caused by the stressor. The list included 31 stressors for the medical unit and 10 for the infantry unit. (2) Physical and mental health outcomes were assessed two different ways: A 7-item depression scale (Mirowsky & Ross, 1992) in which respondents rate the number of days in the past week they have experienced depressive symptoms, and a 20-item general symptomatology scale (Bartone, Ursano, Wright, & Ingraham, 1989) in which respondents rate how often (0=none to 3= very often) they have had a variety of somatic, anxiety and depressive complaints. (3) The third area was composed of individual and organizational factors that might influence adaptation to stress (e.g., level of unit cohesion, feelings about the deployment itself). All respondents were also asked whether or not they had "Tried to reduce tension by drinking more alcohol than usual."

Results

Among medical unit survey respondents, 14.2% reported increasing their use of alcohol as a way of coping with stress compared with 14.6% of the border patrol unit. Thus, two alcohol response groups were identified, those who reported an increase in alcohol use (alcohol increase group) and those who did not (no alcohol increase group). These two groups were then compared in terms of the amount of concern they experienced about a variety of stressors.

Among the medical unit soldiers, MANOVA for alcohol increase and deployment-related stressors was not significant, Hotelling's $T^2(1, 87) = 1.20$, n.s. Nevertheless, because the medical unit was the first peacekeeping unit we studied, we regard as preliminary the subsequent selected analyses which indicate that those in the alcohol increase group reported significantly more stress from news reports than those in the no alcohol increase group, $t(97) = -3.33$, $p = .001$, separation from spouse, $t(96) = -2.20$, $p < .05$, and approached significance for isolation, $t(17.80) = -2.01$, $p = .06$ (Table 1).

In contrast, the MANOVA for the border patrol unit had significant overall effects for alcohol increase and deployment stressors, Hotelling's $T^2(1, 120) = 4.24$, $p < .001$. Subsequent univariate analyses indicates that those in the alcohol increase group report significantly more stress than those in the no alcohol increase group from boredom, $t(61.56) = -4.93$, $p < .001$, isolation, $t(121) = -2.13$, $p < .05$, problems with unit leadership, $t(122) = -3.19$, $p < .01$, trouble making phone calls home, $t(121) = -2.13$, $p < .05$, and the rear detachment, $t(122) = -3.08$, $p < .01$ (Table 2).

For the medical unit sample, a significant correlation was found between overall stress and depression ($r = .55$, $p < .01$) and general symptomatology ($r = .53$, $p < .01$). Similar results were found for the border patrol unit: Total stress levels significantly correlated with depression ($r = .31$, $p < .01$) and general symptomatology ($r = .22$, $p < .05$). As expected, soldiers reporting increased alcohol use reported higher symptom means. In the medical unit, soldiers in the alcohol increase group had higher mean depression scores ($M = 2.12$, $SD = 2.12$) than those in the no alcohol increase group ($M = 1.37$, $SD = 1.29$), $t(98) = -2.15$, $p < .05$, and higher mean general

symptomatology scores ($M=.04$, $SD=.09$ vs. $M=.02$, $SD=.08$), $t(98)=-2.39$, $p<.02$. The same was true for the border patrol unit. Soldiers in the alcohol increase group reported higher mean depression scores ($M=2.53$, $SD=2.00$) than those in the no alcohol increase group ($M=1.25$, $SD=1.32$), $t(25.04)=-2.87$, $p<.01$, and higher mean general symptomatology scores that approached significance ($M=.80$, $SD=.72$ vs. $M=.48$, $SD=.42$), $t(24.10)=-2.01$, $p<.06$.

In terms of unit functioning, the medical and border patrol units responded slightly differently. Again, for the medical unit the overall MANOVA was not significant, Hotelling's $T^2(1, 84)=1.17$, n.s. In subsequent analyses with the medical unit regarded as preliminary, there were no significant group differences on desire to continue the mission, satisfaction with the alcohol policy or level of unit cohesion. There were differences, however, in confidence in one's own skills. Respondents in the alcohol increase group had significantly less confidence ($M=2.81$, $SD=1.11$) than those in the no alcohol increase group ($M=3.43$, $SD=1.13$), $t(95)=2.00$, $p<.05$. In contrast, the MANOVA for the border patrol unit was significant, Hotelling's $T^2(1, 100)=2.19$, $p<.01$. There were no differences in confidence, but those in the alcohol increase group report significantly less satisfaction with the mission, $t(122)=4.45$, $p<.001$, the alcohol policy, $t(120)=3.77$, $p<.001$, personal morale, $t(122)=2.77$, $p<.01$, and unit morale $t(122)=2.32$, $p<.05$ (Table 3).

An analysis of gender differences in the medical unit sample reveals significantly more males who reported an increase in alcohol use than females. Of the 100 male respondents, 18% reported an increase in alcohol use compared to none of the 22 the female respondents. Men also reported higher rates of general symptomatology ($M=.41$, $SD=.32$) than women ($M=.30$, $SD=.21$), $t(45.56)=2.16$, $p<.05$. Interestingly, men and women did not significantly differ on other variables such as age or level of depression. There were no female soldiers in the border patrol sample.

Discussion

Despite differences in occupational specialty and gender composition, about 15% of soldiers in both the medical and border patrol units reported increasing their alcohol use during deployment. Both similarities and differences were found in the significantly elevated stressors reported by those increasing their alcohol intake in the two units. Similar stressors included isolation and separation from spouse. However, in the medical unit, stressors related to safety were elevated concerns for those reporting increased alcohol use. In contrast, border patrol unit soldiers reporting an increase in alcohol use had elevated concerns associated with boredom, knowing the family was being taken care of, and with unit leadership than those who did not report increasing their alcohol use. The medical unit results are not as compelling as the results from the border patrol unit. This difference may be due in part to the medical unit's smaller size, the presence of women (none of whom reporting increased drinking), or the more varied unit composition.

Whereas some of the stressors associated with increased alcohol use are common across types of deployment (such as safety), several appear particularly related to peacekeeping deployment. The stressors reported by those drinking more alcohol are generally consistent with the model for psychological stressors on peacekeeping operations. Isolation stressors were higher for the

alcohol increase group, as was the stress related to separation from one's spouse and contacting one's spouse. Stressors tapping into ambiguity such as mission satisfaction and confidence in training were higher for the alcohol increase group. Powerlessness may also be higher for the alcohol increase group in terms of unit leadership problems. Boredom is clearly higher for the alcohol increase groups in both samples. Finally, threat is higher for those in the medical unit's alcohol increase group as exemplified by news about the former Yugoslavia. Concerns about the rear detachment may reflect general family worries as well as the fact that deploying units are often composed of soldiers drawn from a widely dispersed geographical area leaving individual families isolated and without consistent community support.

Despite the relationship found between alcohol increase, stressors, unit variables and mental health outcome, this study did not specifically assess alcohol abuse, but rather self-reported increase in alcohol use as a way of coping with tension. Similarly, the results are not evidence of a causal relationship between alcohol use and deployment distress. It could be that drinking alcohol led to greater problems and stressor perception, or that others increased drinking but not in response to perceived tension. Given cautious interpretation of the data, however, several preliminary recommendations are possible.

First, stressors associated with increased alcohol use should be specifically targeted. Thus, isolation can be addressed by increasing communication with family members (through newsletter contributions, telephone access, media materials, cultural connections with the local community through cooperative service provision, educational and social opportunities). Separation from spouse can be addressed through improved communication (telephone access, financially facilitated for young enlisted soldiers if possible). Safety fears can be addressed through adequate and fast communication, even when the message is that no information is known. Boredom can be addressed by providing varied recreational activity, but more importantly creating a framework from which the deployment tasks themselves can be viewed as meaningful. Especially in border patrol units, the work can become repetitive and non-challenging. Creative, responsive leadership can remind soldiers that the work is worthwhile and acknowledged.

Second, the variables identified can help target specific soldiers who may be at risk for increased alcohol consumption. Leaders can be trained to look for signs of stress and of the use of alcohol as a coping method. Soldiers who lack confidence in their skills and abilities, who complain about the alcohol policy, who have low morale appear to be at risk for engaging in "escape drinking." These soldiers can be identified and supported with additional training, education, guidance, and attention to morale issues.

Third, an appropriate alcohol policy needs to be identified. There is a wide spectrum of possible alcohol policies from a full ban to full acceptance. The culture of the deployed environment plays an important role in shaping policy. During deployment to Saudi Arabia, for example, alcohol was banned out of respect for the host nation. Other cultures have different norms with regard to alcohol. For example, the medical unit was stationed in a UN camp that contained bars established by several different peacekeeping nations. These bars provided very cheap drinks, entertainment, the chance to meet other peacekeepers, and an active social environment. Thus, alcohol played a critical social role in the lives of many deployed peacekeepers, and to some extent it fostered positive cross-cultural interaction. Nevertheless,

high rates of alcohol consumption have the potential to increase the risk of unwanted incidents (such as barroom fights, harassment, and behaviors influenced by poor judgement). Command must therefore balance the social needs with limits and alternatives.

The study results with regard to gender suggest that women are not as at risk as men for increased alcohol consumption. Of course the results do not exclude the possibility that some women will increase their alcohol intake, a possibility already corroborated by observation, but the results are consistent with the finding that women have rather low alcohol abuse rates. Women are often found to be depressed instead, a finding not supported by this study. In the medical unit sample, women did not have significantly higher rates of depression than men, suggesting that these women may have been particularly able to adjust to the challenges of peacekeeping.

Future research could examine quantitative subjective reports of alcohol intake in order to address those who increase drinking in order to cope with tension as well as those who increase for other reasons. Future research could also compare the different types of deployment on alcohol intake, confirm the gender difference found in this study, assess the perceived impact of increased drinking, and examine the long-term impact of increased drinking on soldier performance and adjustment at redeployment. A comparison of unit deployed for peacekeeping with those deployed for other reasons can help clarify which stressors associated with increased alcohol use are indeed unique to peacekeeping.

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Footnote

- ¹Questions regarding alcohol were only asked on the mid-deployment survey, and responses could not be tracked over time, making analysis over time impossible.

Table 1
Stressor Ratings by Alcohol Response for Medical Unit

Stressor	Alcohol Response Group ¹	
	Alcohol Increase	No Alcohol Increase
News reports of trouble in the former Yugoslavia		
<u>M</u>	2.81	1.58
<u>SD</u>	1.64	1.30
Separation from spouse		
<u>M</u>	2.13	1.12
<u>SD</u>	1.82	1.64
Isolation		
<u>M</u>	2.00	1.02
<u>SD</u>	1.86	1.28

¹All group differences significant at $p < .05$.

Table 2
Stressor Ratings by Alcohol Response for Border Patrol Unit

Stressor	Alcohol Response Group ¹	
	Alcohol Increase	No Alcohol Increase
Boredom		
<u>M</u>	4.45	3.24
<u>SD</u>	.86	1.68
Isolation		
<u>M</u>	3.55	1.87
<u>SD</u>	1.79	1.81
Problems with Unit Leadership		
<u>M</u>	3.68	2.37
<u>SD</u>	1.52	1.79
Trouble Making Phone Calls Home		
<u>M</u>	3.27	2.31
<u>SD</u>	1.83	1.94
Rear Detachment		
<u>M</u>	1.73	.79
<u>SD</u>	1.45	1.25

¹All group differences significant at $p < .05$.

Table 3
Unit Ratings by Alcohol Response for Border Patrol Unit

Stressor	Alcohol Response Group ¹	
	Alcohol Increase	No Alcohol Increase
Satisfaction with the Mission		
<u>M</u>	1.68	2.88
<u>SD</u>	.84	1.17
Satisfaction with Alcohol Policy		
<u>M</u>	1.77	2.76
<u>SD</u>	1.02	1.13
Personal Morale		
<u>M</u>	2.27	2.96
<u>SD</u>	1.03	1.06
Unit Morale		
<u>M</u>	2.05	2.69
<u>SD</u>	1.09	1.19

¹All group differences significant at $p < .05$.